Industrial Insurance Chiropractic Advisory Committee (IICAC) Meeting Minutes
Date: January 17, 2008

IICAC

Final

Present: Robert Baker, DC
Clay Bartness, DC
Roger Coleman, DC
Linda DeGroot, DC
Michael Dowling, DC, Chair
Lissa Grannis, DC
Jay Lawhead, DC
Bill Pratt, DC, Vice Chair
Ron Wilcox, DC
Bob Mootz, DC
Neal Schanbeck
Joanne McDaniel
Janet Blume
Carole Horrell

Absent: La Vonda Mccandless
Guests: NA

General Business

Minutes:
In the 12/13/07 IICAC minutes, the second page of the Evidence Based Practice and Policy discussion notes were missing and the complete revised version will be provided with the January minutes.

Moved, Seconded, Carried: Unanimous vote to approve the minutes as written.

Bylaws:
Bob Mootz distributed the final bylaws signed by Mike Dowling, DC, IICAC Chair and Judy Schurke, L&I Director.

IICAC Subcommittee Structure
Bob Mootz shared a two page spreadsheet of the proposed topics that resulted from last month's full committee discussions and subsequent discussion with the chair. Two standing subcommittees were proposed:

- Evidence-Based Practice, Policy & Quality Assurance (PPQ)
- Provider Education and Outreach (PEO)

Both subcommittees will meet in breakouts during the time scheduled for the regular IICAC meeting in February to review activities and make recommendation for prioritization to the full committee.

Members volunteered and were assigned to each subcommittee as listed below. Bob Mootz, DC, will be the staff resource for the PPQ Subcommittee and Joanne McDaniel will be the resource for the PEO Subcommittee. As chair, Mike Dowling, DC will not serve directly on either committee but will be available to assist either as needed.

- PPQ Subcommittee Members:
  - Bob Baker, DC

- Roger Coleman, DC
- Linda DeGroot, DC
- Jay Lawhead, DC

- PEO Subcommittee Members:
  - Clay Bartness, DC
  - Lissa Grannis, DC
  - Bill Pratt, DC
  - Ron Wilcox, DC

IICAC activities were identified according to activities related to provider education & outreach or evidence-based practice, policy, and quality assurance. Each activity was reviewed and determined to be a existing activity the CAC has been involved and may be straightforward in term of committee member experience and workload or whether additional committee expertise and workload is likely. A draft summary of this work is attached as an appendix.

Evidence Based Medicine

Bob Mootz finished the presentation began at the November 2007 orientation meeting on evidence-based practice, how is it accomplished, its relevance and impact on policy and practice. In summary, EBP focuses on the better use of scientifically derived information to factor in clinical decision making in order to make improvements in patient outcomes.

Higher quality evidence, such as randomly controlled clinical trials, has traditionally been perceived to be a gold standard for its reliability to have applicability to patient care. However, this level of information is frequently limited because of the resources required to conduct such research, the variation in patient populations that may studied, and other confounders such as co-morbid conditions, practitioner's skill and experience, etc.

A crucial element to evidence-based practice is that evidence is a valuable tool to factor into the clinical decision-making process, not a replacement for clinical judgment. The suitability of evidence to answer meaningful clinical questions and variable evidence quality (hierarchies of evidence) factor into the equation. For example anecdotal evidence has far less currency in evidence-based practice than systematically studied assessment of interventions and outcomes in larger, more representative patient populations.

Technology assessments are a tool policy makers use to systematically consider scientific evidence, experience, demand, and policy implications for private and public purchasers to make better informed coverage decisions. In Washington state, recent legislation has required the states public purchaser to be more systematic in using evidence to make health care purchasing decisions including the establishment of a statewide program to rigorously perform technology assessment on medical devises and procedures which will help standardize coverage decisions across state agencies that purchase health care.

The social context of technology assessment has been summarized as follows:

1. Does it work? (effectiveness)
2. Is it needed? (appropriateness)
3. Is it wanted? (informed decision making)
4. Should the public pay for it? (insured services)

Typically, the procedure for new technology assessments follows this sequence:

1. Application by proponents, utilization triggers, or legislative request
2. Staging: coverage and situation specific evidence is necessary
3. Policy analysts review the outcomes. Most are increasingly evidence-based medicine trained (MPH, MPAs, or similar)

There are frequently concerns regarding the formulations of coverage policies and practice guidelines being considered “Standard of Care.” This is a legal term and refers to a decision by a Trier of fact (eg, judge, jury, commission) regarding the reasonableness and appropriateness of a provider’s action compared to that of his or her peers. One of the key challenges for IICAC members and development of future evidence-based practice activities will be to formulate useful resources for clinical decision making that are not readily misinterpreted as decision aid or adjudication tools. The key value of such practice resources to readily provide patients and providers with a better understanding of the evidence surrounding various care options and decisions they need to make.